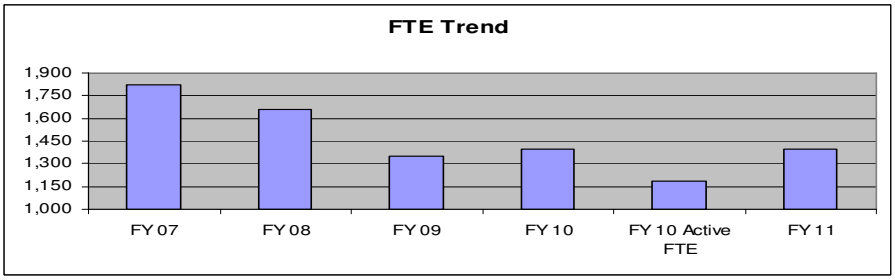
# MHRH Today

## Department of Mental Health, Retardation and Hospitals

The Department of Mental Health, Retardation and Hospitals has three service divisions: the Division of Developmental Disabilities, the Division of Behavioral Health and Eleanor Slater Hospital which is located in Cranston and Burrillville. These three divisions administer supports to approximately 40,000 Rhode Islanders each year. The Department has two additional divisions, Central Management and Hospital and Community System Support, which provide administrative support. As shown in the chart below, there are currently 1189 active employees which is a 44% decrease from the FY 07 enacted FTE level. Currently approximately 112 FTE's are funded thru overtime in RICLAS and 81 FTE's are funded thru overtime at Eleanor Slater Hospital.




The chart represents:
· 34% reduction in union employees
· 61% reduction in non-union employees

**Division of Developmental Disabilities**

The Division administers a system of support to approximately 4200 individuals with developmental disabilities. There are 37 privately-operated providers and one publicly operated provider, Rhode Island Community Living and Supports (RICLAS). Individuals who are found eligible for services are assessed to identify the type and level of support an individual will require. Individuals and/or their families choose the agency from which they will receive supports and have input in the manner in which supports are delivered. Included in the Governor's FY 11 budget is a Lead Agency initiative which is projected to save $7 million, $2.5 million in general revenue.

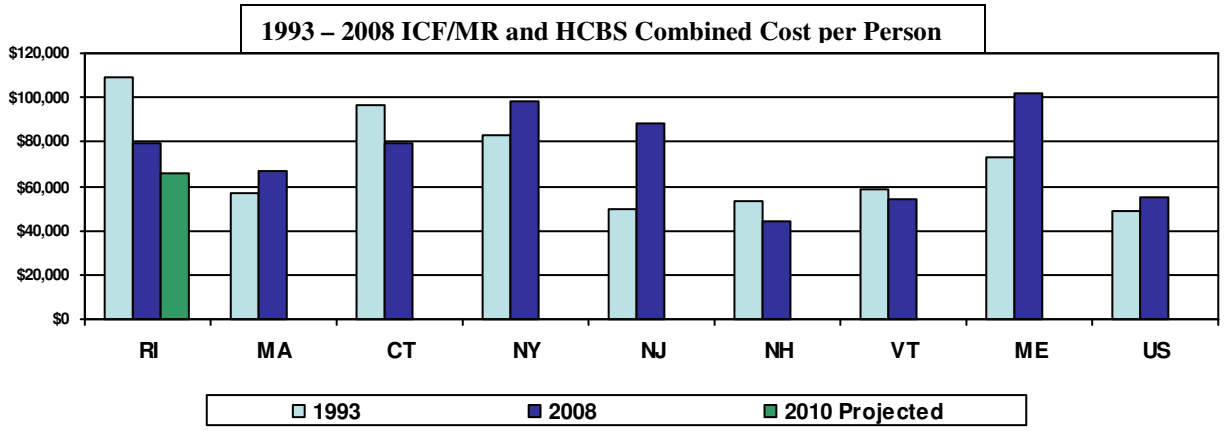
Historically, the RI Developmental Disability system has been considered to be expensive. The Human Services Research Institute compiled the causes for the increased cost which are noted in the listing to the right. Since 1993, Rhode Island has dramatically reduced the cost per person by 40% from $108,916 to a projected $65,624 for FY 2010 (see figure on following page).

**Why has the RI system historically been considered to be expensive?**

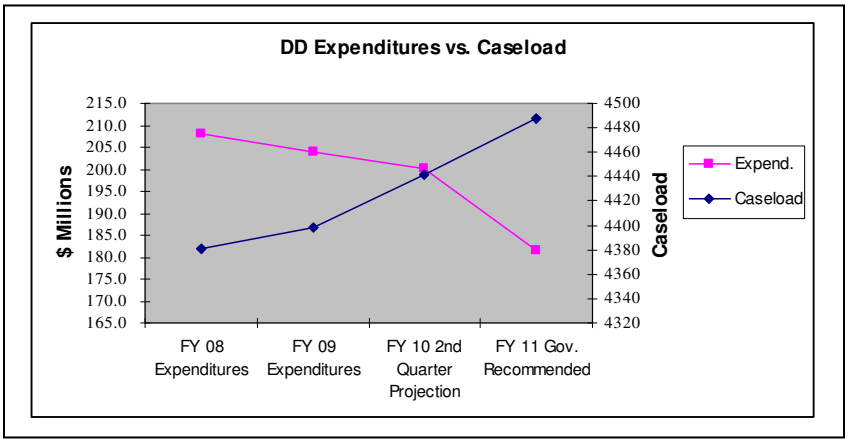
- Higher Cost of Living in the Northeast
- Greater incidence in comparison to other states 211/100,000 in RI, 144/100,000 national average
- Small group home size of 1 – 6 beds and no state institution (e.g. No economy of scale)
- Prior to 2008, increased usage of group homes for residential supports instead of alternate settings
- Policy to serve a large number of individuals and not have a wait list
- Strong quality enhancement systems such as self-determination and choice of services

Since 2008, the number of individuals who receive 24 hour support in group homes has decreased by 16%, while the number of individuals who live in shared living arrangements (SLA) has grown by more than 50%. During the same period, there has been a growth in day

program supports and continued use of family and non-overnight supports. These changes have resulted in a lower combined cost per person, comparable to that of other New England states as shown in the below figure.

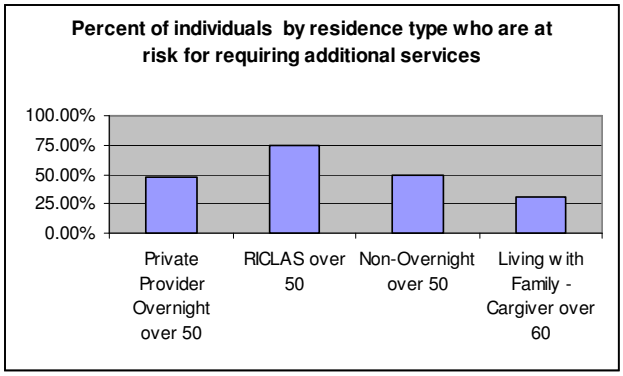



The Department has worked diligently to reduce expenditures through rate cuts and diverting individuals from group home placements to less costly day program, family and/or shared living supports as well as keeping administrative costs to a mere 3.1% of the DD budget. During the same period, the Department has been faced with an increasing caseload.




Adding to the challenges we face in treating more individuals with fewer dollars is the issue of the aging DD population in RI. Individuals with developmental disabilities experience age-related medical issues earlier than the general population. Given increasing medical issues, onset of Alzheimer's Disease and other health-related factors affecting elderly disabled populations, we anticipate significant increases in individual's need for support over time.

The chart to the right represents approximately 800 individuals who live in less costly settings and 800 individuals who currently live in a group home who will surely require additional supports in the coming years. There are approximately an additional 170 eighteen to twenty year-olds who are eligible but do not receive services yet. The increasing Autism rate also will create more demand.




The Department's Lead Agency Initiative proposes to reduce administrative costs incurred at provider agencies, revise the rate structures, and systematically review high-cost cases. The principles and goals of the proposal are as follows:

- Consumer Choice in agency and input into service plan
- More seamless and timely access to services
- Accountability for quality and economy of service provision
- Sustainability of the system of care for the long term

The initial timeline to achieve the savings required implementation of the proposal by July 1, 2010. At this time, projected implementation has been delayed to October 2010 due to extensions on the RFI and requirement to go to bid for consultant services. To the extent that there are further administrative delays, implementation will also be delayed and will minimize the total estimated savings.

| | |
|---|---|
| 1/20/2010 | MHRH Staff meet to formalize model and develop RFI |
| 2/15/2010 | RFI is posted |
| 3/10/2010 | MHRH Responses to initial RFI questions are posted |
| 3/20/2010 | All RFI's are received by the Department |
| 3/22/2010 | The RFP for the consultant is posted |
| 4/15/2010 | Responses to the remainder of RFI questions will be posted |
| 4/22/2010 | Responses to RFP due |
| May 2010 | Consultant Chosen, Rate definition and development, and Lead Agency RFP development |
| Jul 2010 | Lead Agency Procurement and CMS Review and Approval |
| Sept 2010 | Network Start-up |
| Oct. 2010 | Consumer enrollment |

**Eleanor Slater Hospital**

The past several years have been a period of significant change and challenge for Eleanor Slater Hospital. Staffing and census both have been substantially reduced, and the make-up of the Leadership Team has undergone dramatic change. The Hospital's accreditation was threatened with the threat resolved. The financing mix has shifted and a new direction established. A broad agenda of organizational change and cultural transformation has been defined and launched.

The most obvious difference one sees is in the sheer **size** of the Hospital. A licensed 495-bed Long Term Acute Care Hospital, operating on two campuses, Slater is like every other hospital in the state in that it operates at lower than licensed capacity. The Budget approved by the General Assembly for FY2009 assumed a planned reduction in average census, from 365 to 300, with an associated reduction in staffing, from 1,047 (December 2007) to roughly 900 (later reduced to 852 in the FY2009 Revised Budget). As can be readily seen in the table on the right, those reductions were not only realized, but ***exceeded***. In fact, as a result of two waves of retirements in CY2008, Slater lost over **160** long-time and senior employees, among them nearly the entire

**Staffing and Census History**

| | FTE's | Census |
|---|---|---|
| FY2004 | 1,153 | 356 |
| FY2005 | 1,160 | 363 |
| FY2006 | 1,154 | 358 |
| FY2007 | 1,115 | 352 |
| FY2008 | 1,024 | 365 |
| FY2009 | 766 | 300 |
| March 2010 | 746 | 265 |

Leadership Team. In less than nine months, Slater lost its CEO, COO, Chief Medical Officer, all but one of its Nurse Managers, as well as the Managers of the Pharmacy, Laboratory, Dietary, and Housekeeping Departments to retirement.

So, in addition to a significant reduction in force necessitated by budget constraints, there was a dramatic "brain drain" that had an understandably disruptive impact on the operation of the Hospital. Staff at all levels were thrust into new roles with little or no preparation, usually on temporary assignment, and we are still working through the process of converting many of those employees to permanent status.

It is also important to understand that, like all large organizations, Slater is not a static environment. Although we have recruited and added more than eighty positions since December 2008, there is constant and continued attrition, and we have actually *lost* ground against full staffing as a consequence.

Perhaps partially as a consequence of this disruption of staffing and leadership, the Hospital's accreditation status with the Joint Commission was placed in jeopardy. The Joint Commission conducted its triennial accreditation survey of Eleanor Slater in December 2008. Unlike other years, the surveyors identified a series of systemic failures throughout the Hospital that resulted in fifteen serious deficiencies ("Requirements for Improvement") requiring formal Corrective Action. Fifteen RFI's meant that the Hospital was placed on Conditional Accreditation status.

The Corrective Action planning and implementation process consumed much of CY2009, and formed the foundation for a disciplined and thorough re-examination of Hospital operations, structure, and practice standards, literally top to bottom and hospital unit by hospital unit. The success of that effort was demonstrated when the Joint Commission returned in September to re-survey the Hospital, and agreed that all fifteen RFI's had been resolved, returning Eleanor Slater to **FULL** Accreditation.

For years, the Hospital has been totally reliant on state and Medicaid funding. One of the goals for FY2009 was to renovate the financing mix of the Hospital. We were successful in several regards:

- We realized nearly **$3 million** in new Medicare revenue (100% federal funding);
- We were able to qualify most of the patients in the Forensic Unit, who had previously been 100% state cost, for Medicaid (64% federal funding); and
- We opened up negotiations with commercial insurers.

All of these actions were consistent with a shift in the Hospital's mindset – that we wanted to act less like a "typical" state agency, and more like a **PROVIDER**. All of these efforts, plus close managing of our resources meant that not only was an inherited structural deficit resolved, but the Hospital finished the year, for the first time in many years, with **no deficit**.

Going forward to FY2011 and beyond, Eleanor Slater continues its transformation, with two strategic efforts:

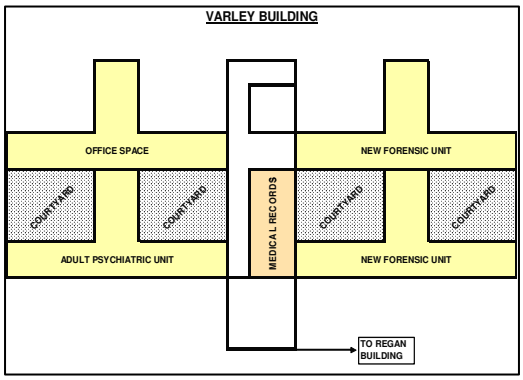
**First**, Slater is **re-assessing its core function**, and how it sits in the overall system of care:

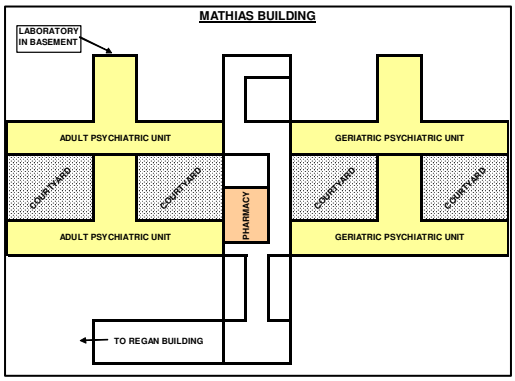
- What patient **populations** do we serve?
- Where do they come from? What are their needs, and how do we address them?
- How does ESH provide value to the balance of the system?
- **Why** is ESH the ***best*** place for these patients?
- What is their **next** destination after ESH?
- What are the special challenges we face in treating these patients?

Going forward we want to focus on developing clinical lines of business that build on core competency and niche markets, and **target alternative revenue streams** (Medicare, Commercial

Insurance, etc. vs. State/Medicaid), and we will continue to **look within** to identify improvements that strengthen the Hospital, while reducing waste.

**Secondly**, we are proposing a $29 million consolidation of Hospital buildings on the Pastore Campus. This project, the first major building program at the Hospital in nearly thirty years, will result (by CY2013) in a reduced Hospital "footprint" on the Pastore Campus – from eleven units across four buildings to ten units within a connected building system. By deploying patient care over a more efficient building footprint we project reductions in staffing costs as well as the Hospital's maintenance and utility budget, while at the same time providing a much more appropriate environment for patient care. The buildings currently housing these programs were built in the 1930's, in an entirely different ***era*** of patient care.

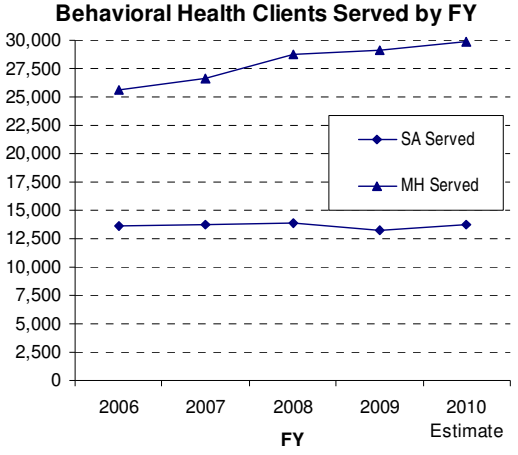



**Division of Behavioral Health**

The Division (DBH) administers a system of care that provided clinical treatment services and supports for over 42,000 individuals in FY 2009. The system of care consists of 104 funded, community-based providers, augmented by discretionary grants from the Centers for Mental Health Services and Substance Abuse Treatment. The DBH incorporates the formerly separate Divisions of Integrated Mental Health and Substance Abuse Treatment. The Division of Behavioral Health Services (DBH) is responsible for planning, coordinating, and administering comprehensive statewide systems of substance abuse prevention and the promotion of mental health; screening and brief intervention; early intervention and referral, substance abuse and mental illness clinical treatment services, and recovery support activities. Effective with the SFY 2011 budget, the Division is consolidating the formerly separate Integrated Mental Health and Substance Abuse Treatment Services.

DBH served 13,304 unique individuals in the substance abuse treatment system and an additional 29,117 were served by the mental health treatment system in FY 2009. These systems are projected to serve 13,703 and 29,873 individuals, respectively, in FY 2010 (see figure to right)




In comparing unique clients served in the substance abuse and mental health systems, it appears that demand for service from the mental health system continues to increase substantially, while remaining relatively stable

for substance abuse. Demand for mental health services has increased by nearly 20% since 2006 and the increase for 2011 will probably match 2010 at 2.5%.

However, the difference in the rate of increase of clients served in actuality results from differences in funding sources for the two client populations. Individuals served in the mental health system, especially those with serious and persistent mental illness (SPMI) designations and/or meeting community support population (CSP) criteria typically are found eligible for Medicaid, and treatment is paid on a fee-for-service and per diem basis. Addictive disorders do not qualify an individual for Medicaid. The primary funding sources for substance abuse treatment are state general revenue and federal block grant dollars. This funding allocates a finite number of slots and beds to serve individuals in all levels of care for substance abuse treatment. As unemployment rates increase, the demand for substance abuse services for the uninsured will continue to rise, but the ability to respond is capped by the number of treatment slots available.

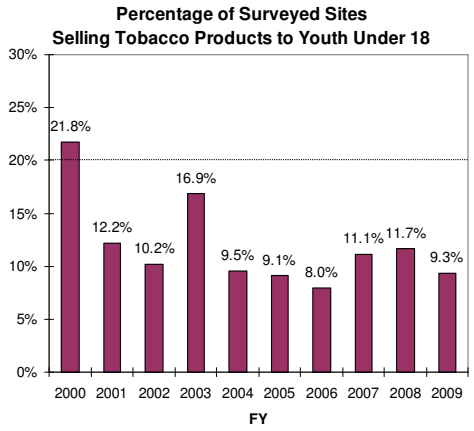
As shown above, demand for mental health services has continued to grow at an average of **five percent (5%)** per year for the past four years, and there are no signs that demand will ease in FY2011. This increased demand, coupled with several years of rate and budgetary pressure, has challenged the department and the treatment system as a whole.

In response, the Department proposed to develop a contract offer for FY2011 for behavioral health treatment services that would normalize and stabilize payment across the system and provide a more **sustainable** model of financing to the system as a whole while avoiding ongoing formula cuts. This proposal attempts to address a significant variability (by provider) of per person treatment costs across the system, and seeks to provide a financial incentive to providers that evidence or adopt a ***recovery*** model of treatment.

In addition to the above, the FY 11 behavioral health budget reductions include: modifying the payment for psychiatric rehabilitation and treatment planning, implementing changes to emergency billing and eliminating TASC. It is important to note that in FY 09 and FY 10, the Department implemented the following reductions: reduced contracts, implemented length of stay and fee for service requirements, decreased funding for the supportive housing program and increased co-pays for methadone. The Department also achieved the most general revenue savings under the CNOM provision of the Global Waiver. The Department has worked with providers to implement the CNOM's which will total nearly $15.4 million in FY 2011, which equates to over $8 million in general revenue savings. Note that the implementation has been difficult at best. For the State, issues have arisen related to programming for claims adjudication and auditing provider agencies. For provider agencies, there are additional administrative requirements.

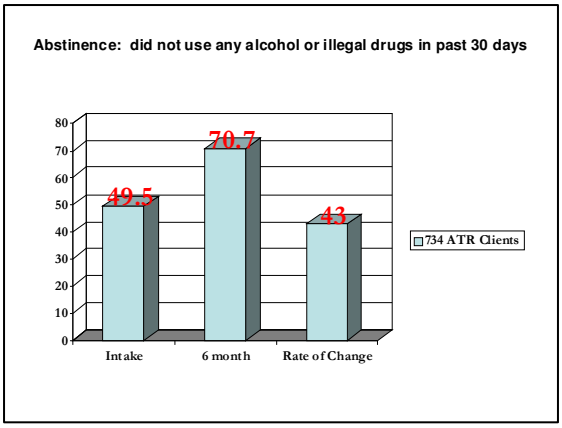
Substance abuse prevention and mental health promotion services are provided through contracts administered in DBH and managed across the department. Prevention services are provided through 35 contracts with municipalities funded through the Rhode Island Substance Abuse Prevention Act, three contracts with community based providers funded through the Student Assistance Program and the Substance Abuse Prevention and Treatment Block Grant (SAPT BG), two contracts funded through the Governor's portion of the Safe and Drug Free Schools formula grant administered by the federal Department of Education, 11 contracts funded through the SAPT BG, and one contract funded by the Enforcing Underage Drinking Laws Block Grant administered by the federal Office of Juvenile Justice and Delinquency Prevention. Through these programs, residents of all of the state's 39 municipalities are exposed to public education and other strategies designed to change community norms, prevent alcohol and other drug use, and arrest the progression from initial substance use to abuse and dependency.

The department also administers a program to reduce youth access to tobacco products. The state has consistently maintained a tobacco sales rate well below the national performance standard of 20 percent.




On September 20, 2007, the Department was informed that the state of Rhode Island was being awarded an Access to Recovery grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Access to Recovery (ATR) program is part of a Presidential initiative to provide client choice among substance abuse clinical treatment and recovery support service providers, expand access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increase substance abuse treatment capacity. Rhode Island received 2.75million dollars each year for the three years of the grant. Since 2007, ATR has served approximately 3000 clients providing clinical treatment and recovery support services. In its' 2.5 years of implementation, the Department developed a complete transformation of how services needs were assessed, met and paid for. Targeted populations included uninsured, indigent individuals who were involved in DCYF, the criminal justice system and/or the Training School. Throughout the duration of the grant, the populations were expanded to include federal probationers, National Guard members and their families, and frequent recidivists of the State funded Detoxification program.

Other successes of the ATR program include the enhancement of recovery support services, increasing the community support for individuals trying to attain/maintain recovery. These services include, but are not limited to; employment assistance, recovery housing, life skills, recovery coaching, transportation assistance, child care, and spiritual support. All client based information is hosted on the electronic voucher system including; assessment, approved services, utilization, and payment information. This electronic system has improved care coordination and enhanced the Department's use of data. Each client is provided initial and six month outcome evaluations. With an average cost per client of $2272, the success of the program has been remarkable. Over the course of the grant outcome survey data reports the following results:[1]



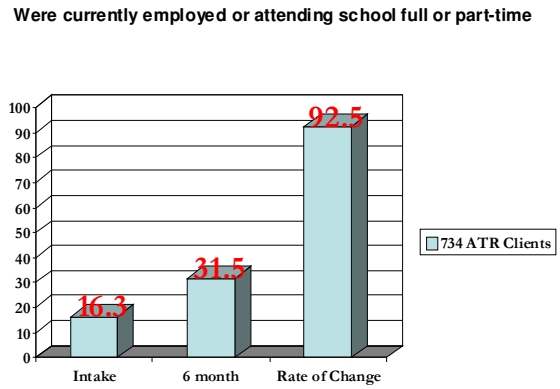

As presented to the right, abstinence rates for the 30 days prior to being interviewed improved by 43%.

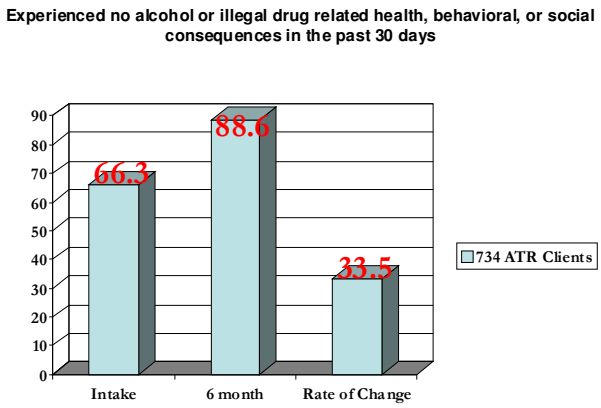
Arrest rates declined. No arrests in last 30 days improved by 2.6% (overall rate reporting no arrest at 6 month follow-up was 96% - low rate of change is affected by those reporting no arrest 30 days prior to intake – due to incarceration at the time).

[1] This data is for all ATR clients who completed an outcome survey 5 to 8 months post intake, from the beginning of the program through January of 2010.

Employment and Education (those currently employed or in school) rate improved by 92.5%.

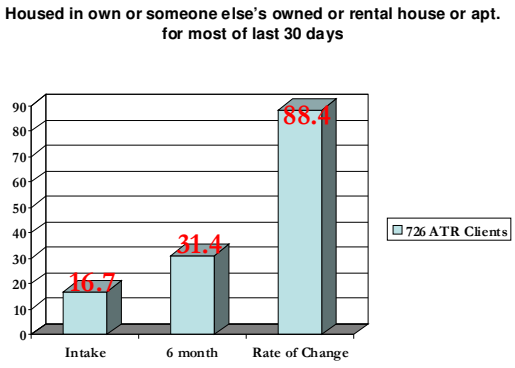
No negative consequences related to alcohol or illicit drug use rate improved by 33.5%.




Social connectedness rate improved by 6% (with overall rate reported at follow-up to be 92.6%).

Stability in Housing rate improved by 77.8%.




The Department continues to implement the Transitioning from Prison to Communities Program. This program provides residential or intensive outpatient substance abuse treatment services to parolees for whom these services are a required condition of parole. This funding has increased capacity at residential treatment programs and allowed inmates who were previously waiting in prison for a state-funded residential bed to become available to have quicker access to treatment. All referred parolees receive a standardized assessment by a Licensed Chemical Dependency Professional and are then referred to the appropriate clinical setting. To date, 471 assessments have been completed with 373 admissions to residential treatment and 52 IOP admissions.

**New Emphasis:**

The Department has placed a new emphasis on expanded housing opportunities and employment services. This began with the Department's decision to shift its homeless PATH funding to increase outreach for the Housing First program. The Department through the Threshold Program and through turning over vacant property over to community providers has in the past eighteen months has created over 100 new units of transitional or permanent housing. Some of these initiatives have focused on homeless veterans, families with disabled individuals, and women.

The Department has now embarked on a similar path to focus on employment opportunities and transform some of our day activities into real employment development for individuals with disabilities. The initiative will follow an "employment first' model"

"Without a roof over ones head and a decent job, it is impossible for someone to reach and sustain their recovery."

Craig Stenning, Director